



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

DALLAS COUNTY SCHOOLS

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-09-3202-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our company has purchased national hospital payment data from 'Cleverly and Associates': a nationally recognized company. This data is known as Med Par Data based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable... The PAF we have established is 250% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region."

Amount in Dispute: \$21,240.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent is of the position that its payments and reductions or denials were appropriate, and seeks and order denying g further payments to Requestor. Additional reimbursement is not reasonable or necessary based on the documentation submitted for this medical dispute. Respondent is not entitled to additional reimbursement for the above referenced date of service."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, Texas 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2006	Outpatient Services	\$21,240.82	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 30, 2007.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 143 – Portion of payment deferred.
 - 133 – The disposition of this claim/service is pending further review. Please submit invoice for additional consideration.
 - W3 – Additional payment made on appeal/reconsideration.
 - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - W4 – Denied CPT code 29979 (abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture. No additional reimbursement allowed after review of appeal/reconsideration. Chondromalacia has been disputed.

Findings

1. The insurance carrier denied disputed services with reason code W4 – "Denied CPT code 29979 (abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture. No additional reimbursement allowed after review of appeal/reconsideration. Chondromalacia has been disputed." On November 21, 2008 the Division contacted Pat Piper, the insurance adjuster for this claim. She stated that the current dispute involves medical fees only and that extent of injury is not disputed for the services in dispute. The Division additionally contacted Timothy White of Harris & Harris, the attorneys for the respondent. He confirmed that only the fees are disputed for the services in this dispute and that extent of injury is not disputed for these services. The Division therefore concludes that there is no current dispute as to extent of injury regarding the services in dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.307(c)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the carrier response to the provider's initial bill. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).
3. 28 Texas Administrative Code §133.307(c)(2)(C), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "the form

DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the *Table of Disputed Services* finds that the requestor has listed the disputed dates of service as "12/11/06-12/12/06" and "12/04/06." Review of the submitted documentation finds that the actual date of service was December 4, 2006 only. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C). However, the Division has determined that the dates listed on the requestor's *Table* are the result of a typographical error. The Division will deem the disputed date of service to be December 4, 2006 for the purpose of this review.

4. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Our company has purchased national hospital payment data from 'Cleverly and Associates': a nationally recognized company. This data is known as Med Par Data based on this data, we have established a PAF or payment adjustment factor to be applied to our hospital specific Medicare OPPS reimbursement rate and determined this to be our interpretation and application of fair and reasonable... The PAF we have established is 250% of our hospital specific Medicare Outpatient Prospective Payment System reimbursement rate; this rate is consistent with most commercial and private payers with in this region."
 - Review of the submitted information finds that the data does not support the reimbursement amount sought by the requestor.
 - The requestor did not explain how it determined that a payment adjustment factor of 250% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
 - The requestor did not submit documentation to support that a payment adjustment factor of 250% of the hospital specific Medicare Outpatient Prospective Payment System reimbursement rate would result in a fair and reasonable reimbursement for the services in dispute.
 - The requestor did not submit documentation to support that this rate is consistent with most commercial and private payers in the region.
 - The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

_____	Grayson Richardson	February 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	_____
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.